STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #30561, #30989, #31064, #31303, and #31579, were completed at Mt. Juliet Health Care Center, on April 23 through April 30, 2013, with a partial extended survey completed on April 30, 2013. Based on survey findings for complaint investigation #31064, the facility was cited Immediate Jeopardy for past non-compliance due to a resident elopement on December 23, 2012. Immediate Jeopardy is a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, Director of Nursing, two focus team members, and the Regional Director of Operations were notified of the Immediate Jeopardy on April 30, 2013, at 4:20 p.m., in the conference room. The Immediate Jeopardy was effective December 23, 2012, through January 11, 2013. The facility Quality Assurance (QA) Committee met on December 24, 2012, and began implementation of a corrective action plan. The Administrator and Director of Nursing implemented a new Elopement Risk assessment form on December 23, 2012, and the Director of Nursing began reassessing all residents on December 23, 2012. The QA action plan was fully implemented on December 26, 2012, and monitoring is ongoing with chart audits completed by the Director of Nursing (DON); completion of the Elopement Risk Assessment tool on admission, significant changes, and quarterly; monitoring safety devices for placement and functioning by the Administrator; and reporting to and monitoring of	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 the corrective action plan by the QA Committee. The QA Committee met on January 11, 2013, and no problems were identified with the action plan implemented. The facility attained substantial compliance with F323 on January 11, 2013. Interview with the Administrator on April 30, 2013, at 12:45 p.m., in the conference room, confirmed no other elopements had occurred at the facility since the elopement on December 23, 2012. Substandard Quality of Care was cited under tag F323 at a scope and severity level of "J." No deficiencies were cited related to complaint investigation #30561, #30989, #31303, and #31579.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, review of Incident Detail (police) report, review of weather underground temperatures, review of facility policy, and interview, the facility failed to provide supervision to prevent elopement of a resident (#3) with a new onset of cognitive impairment of ten	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 residents reviewed. The facility's failure to provide supervision for resident #3 resulted in Immediate Jeopardy for resident #3. (Immediate Jeopardy is a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.) The Administrator, Director of Nursing, two Focus Team members, and the Regional Director of Operations were notified of the Immediate Jeopardy on April 30, 2013, at 4:20 p.m., in the conference room. The Immediate Jeopardy was effective December 23, 2012, through January 11, 2013. The Administrator and Director of Nursing implemented a new Elopement Risk Assessment form on December 23, 2012, and the Director of Nursing began re-assessing all residents on December 23. The facility Quality Assurance (QA) Committee met on December 24, 2012, and began implementation of a corrective action plan. The QA action plan was fully implemented on December 26, 2012, and monitoring is ongoing with chart audits completed by the Director of Nursing (DON); completion of the Elopement Risk Assessment tool on admission, significant changes, and quarterly; monitoring the safety devices for placement and functioning by the Administrator; and reporting to and monitoring of the corrective action plan by the QA Committee. The QA Committee met on January 11, 2013, and no problems were identified with the action plan implemented. The facility attained substantial compliance with F323 on January 11, 2013.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 The findings included: Resident #3 was admitted to the facility on December 20, 2012, with diagnoses including Senile Dementia, Hypertension, Hyperlipidemia, and Arthritis. Medical record review of the Nurse's Admission Assessment dated December 20, 2012, revealed "...Mental Status: Alert...forgetful...Able to make decisions: No..." Continued medical record review of the Nurse's Admission Assessment dated December 20, 2012, revealed "Wanders" not indicated. Medical record review of the Admission note dated December 20, 2012, revealed "...confused to day of the week..." Medical record review of the Admission Care Plan dated December 20, 2012, revealed "...Cognitive/Mental/Behavioral...Oriented to: person...place...time...forgetful...patient will have fewer periods of (behavior) forgetfulness..." Medical record review of the Daily Skilled Nurse's Note dated December 20, 2012, revealed "...Cognitive...Alert...Short Term Memory (no recall after 5 Min (minute)...Impaired decision making..." Medical record review of a Physician's Progress Note dated December 21, 2012, revealed "...Pt (patient) with MS (mental status) changes..." Medical record review of a Daily Skilled Nurse's Note dated December 21, 2012, at 11:00 p.m., revealed "...Cognitive...Alert...Short Term Memory	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 (no recall after 5 min.)...Impaired decision making...A&Ox2 (Alert and oriented times)...Crying episode x 1 when friend who was visiting got ready to leave...PRN (as needed) Xanax (anti-anxiety) at HS (at bedtime) per request for nerves..." Medical record review of a Daily Skilled Nurse's Note dated December 22, 2012, at 11:00 p.m., revealed "...Cognitive...Alert...periods of anxiety during shift..." Medical record review of a facility investigation and a Nurse Event Note dated December 23, 2012, at 4:30 a.m., revealed "...Location Incident Occurred: outside facility...Type of Occurrence: unobserved...resident left building through the cafeteria around 4:30 A (morning). Employees began searching for resident between 4:30 A and 5:00 A. Director of nursing, family, administrator, and police were notified immediately after resident was discovered missing. Police located resident outside of facility around 5:00 A. Ambulance was called to scene of incident and resident was taken to (hospital)...Interventions...more frequent checks..." Review of the facility investigation and a witness statement by Certified Nurse Aide (CNA) #1 dated December 23, 2012, revealed "(On December 23, 2012)...at 4:30 (a.m.) walked past (residents) room and noticed (resident) in the bathroom...(resident) said...was getting ready for...son to pick...up...told me...was going to sit in...room for a while...about 2 minutes later...I heard the alarm on the front door go off and saw Licensed Practical Nurse (LPN) #1 and LPN #2	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5 take off running...(resident) tried to go out the front door LPN #2 told (resident) to sit at the nurses station...about 10 mins (minutes) later (approx. 4:50 a.m.) I returned to the nurses station and (resident) wasn't there. At that point I told the nurses I didn't see (resident) and we all fanned out checking...the women in the kitchen said they heard the alarm go off but they checked and no one was out there..." Review of the facility investigation and a statement signed by CNA #1 dated December 23, 2012, revealed "...The patient was wondering (wandering) around and told to sit at the nurses station...then left...about 10 minutes later the patient was not at the nurses station..." Review of the facility investigation and a witness statement signed by LPN #1 dated December 23, 2012, revealed "...I was notified by (CNA #1) that a resident was missing...resident had exited...room and was directed to the nurse's station to sit down...that is when (resident) went missing..." Review of the facility investigation and a witness statement signed by LPN #2 dated December 23, 2012, revealed "...Unable to locate resident asked kitchen employees if they had seen a resident kitchen staff told me they heard the door alarm when they checked to see if anyone had left or come in they did not see anyone..." Review of the facility investigation and a written statement signed by Dietary Aide #1 dated December 23, 2012, revealed "...came in at 4:45(a.m.) knocked on the door (dietary) (Baker #1) let me in, put my stuff down, went to the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6 bathroom, came out of the bathroom, heard the door alarm going off, looked out the door, (there) was no one there..." Review of an Incident Details Report (police report) dated December 23, 2012, revealed the police had been called at 4:59 a.m., arrived at 5:03 a.m., and located the resident at 5:04 a.m. Review of Weather Underground temperatures for Mount Juliet, TN revealed the temperature on December 23, 2012, at 4:30 a.m., was 34 degrees F (Fahrenheit). Review of the Emergency Department Attending History and Physical dated December 27, 2012, revealed "...presents as a level I Trauma after a fall. (Resident) reportedly escaped from a nursing home...found 45 minutes later by police laying on the ground...found confused, cold and with bruising over left face and hip..." Review of a Palliative Care Discharge Summary dated December 27, 2012, revealed "...injuries include left rib fractures, right mandibular (lower jawbone) fracture with fracture of ear canal, and hematoma (collection of blood outside a blood vessel) in frontal gyrus (1/3 frontal lobe of brain)...severe agitation...family plans...hospice today..." Review of a Care Partner Report (hospice) dated January 5, 2013, revealed "...Passed at 4:55 p.m..." Review of facility policy, Missing Patient Procedure, dated December 2012 revealed no procedure for elopement.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 Interview with the Administrator on April 24, 2013, at 3:40 p.m., in the conference room, revealed the facility had no policy for elopement on December 23, 2012. Continued interview revealed the only assessment for elopement and wandering had been completion of the Nursing Admission assessment on admission with wandering addressed under behaviors with a check mark. Further interview at this time confirmed the resident had not been listed on the daily Wander Guard Transmitter Testing Log December 20 through December 23, 2012. Interview with LPN #1 on April 30, 2013, at 6:35 a.m., by telephone, confirmed the LPN had been the Nurse assigned to the resident on December 23, 2012. Continued interview confirmed the LPN had not been aware the resident had been out of bed dressed and had not been told the resident had attempted elopement. Interview with LPN #2 on April 30, 2013, at 8:00 a.m., by telephone, confirmed the resident attempted to exit the front door, the alarm sounded, and the resident had been brought back to the nurse's station. Continued interview confirmed the resident had been up several times the night of December 23, 2012. Interview with LPN #3 on April 30, 2013, at 8:20 a.m., by telephone, confirmed the resident had attempted to "get out of the front door." Continued interview confirmed LPN #1 had been informed of the exit seeking. Interview with Dietary Aide #1 on April 30, 2013, at 8:35 a.m., in the main dining room, confirmed	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 the door alarm in the main dining room alarmed at approximately 4:45 a.m. Continued interview confirmed the Dietary Aide did not see a resident outside when the Dietary Aide opened the door and looked out, reset the alarm, and had not informed the nursing staff the door alarm in the main dining room had alarmed. Interview with CNA #1 on April 30, 2013, at 8:40 a.m., by telephone, revealed the CNA had witnessed the resident on December 23, 2013, at approximately 4:30 a.m., attempting to open the front door and exit the building. Further interview confirmed the resident had been placed at the nurse's station in a chair while nurses had been in the hall passing medications and other staff were assisting residents to get out of bed. Continued interview confirmed the CNA returned approximately ten minutes later and the resident had not been at the nurse's station. Interview with the Administrator on April 30, 2013, at 9:05 a.m., in the Main Dining Room, revealed the door alarm sounded after the dining room door had been opened if the door code had not been entered. Continued interview confirmed the staff had to enter the door code in to silence the door alarm. Further interview confirmed the facility determined the main dining room door had been the point of exit; the location the resident had been located off the premises (approximately 450 feet) had been up a hill and a paved parking lot of a business on a five lane highway. Interview with Baker #1 on April 30, 2013, at 10:05 a.m., by telephone, confirmed the door alarm in the main dining room alarmed, the Dietary Aide reset the alarm, and nursing had not	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 been made aware of the alarm. Interview with Focus Team Member #1 on April 30, 2013, at 1:05 p.m., in the conference room, revealed prior to December 23, 2012, the facility assessed residents for wandering by reviewing admission History and Physical, Minimum Data Set, observation, and interviews. Continued interview confirmed the facility had no policy for elopement or a formal elopement risk assessment. Interview with the Administrator on April 30, 2013, at 1:35 p.m., in the conference room, confirmed the facility had not put an intervention in place to prevent the resident from exiting the building after the resident exhibited exiting seeking behaviors and did not provide supervision of the resident to prevent elopement from the facility. Interview with the Administrator on April 30, 2013, at 2:15 p.m., in the conference room and review of facility documentation provided, confirmed the facility Performance Improvement/Quality Assurance Committee convened and initiated an investigation into the root cause of the elopement. A corrective action plan was initiated on December 23, 2012, all interventions were in place on December 26, 2012, and facility wide staff reeducation was completed on December 24, 2012. Monitoring is ongoing with random chart audits completed by the DON, accuracy of the placement and functioning by the Administrator, and reporting to and monitoring of the corrective action plan by the Performance Improvement/Quality Assurance Committee. The corrective action plan included:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 1. Facility wide chart audits to ensure all residents were assessed for potential elopement risk, updating assessments as needed, and applying safety devices as needed. 2. Routine safety devices were monitored every two hours to ensure that the safety device had been maintained. 3. An Elopement Risk Assessment was put in place to detect potential risk factors and assist the facility in the decision to place a safety device on residents. 4. An Elopement policy and procedure was developed to attempt to reduce resident's risk of elopement. 5. Nurse Aide assignment sheets were reviewed and updated after the resident had been reassessed for elopement risk. 6. Resident Care Plans were updated with the current elopement risk assessments. 7. A notebook with current photographs of the residents identified as an elopement risk was placed at the nursing station. 8. All facility staff were in-serviced and re-educated on elopement precautions/procedures, door alarms, exit seeking behaviors, the elopement book, and the elopement assessment. 9. The QA Team reviewed daily residents with elopement risk/wander guards in place for accuracy and functioning. Interviews with two Registered Nurses, two Licensed Practical Nurses, two Certified Nurse Aides, the Social Worker, and two Dietary employees on April 30, 2013, confirmed all had received education and were able to verbalize the facility's policy and procedure for residents at risk	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 for elopement. C/O # 31064	F 323		